



4191-02U

SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA-2013-0047]

Social Security Ruling, SSR 14-2p;

Titles II and XVI: Evaluating Diabetes Mellitus

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 14-2p. This SSR provides information about the types of impairments and limitations that result from diabetes mellitus (DM). It also provides guidance on how we evaluate DM in disability claims under titles II and XVI of the Social Security Act.

DATES: *Effective Date*: [INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER].

FOR FURTHER INFORMATION CONTACT: Cheryl A. Williams, Office of Medical Policy, Social Security Administration, 6401 Security Boulevard, Baltimore, Maryland 21235-6401, (410) 965-1020.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

SSRs make available to the public precedential decisions relating to the Federal

old-age, survivors, disability, supplemental security income, and special veterans benefits programs. We may base SSRs on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or regulations, they are binding on all of our components. 20 CFR 402.35(b)(1).

This SSR will be in effect until we publish a notice in the Federal Register that rescinds it, or until we publish a new SSR that replaces or modifies it.

(Catalog of Federal Domestic Assistance, Program Nos. 96.001, Social Security—Disability Insurance; 96.002, Social Security—Retirement Insurance; 96.004—Social Security—Survivors Insurance; 96.006, Supplemental Security Income.)

Dated: May 22, 2014.

Carolyn W. Colvin,
Acting Commissioner of Social Security.

POLICY INTERPRETATION RULING

TITLES II AND XVI: EVALUATING DIABETES MELLITUS

PURPOSE: This SSR provides information about the types of impairments and limitations that result from diabetes mellitus (DM). It also provides guidance on how we evaluate DM in disability claims under titles II and XVI of the Social Security Act (Act).¹ We provide information about endocrine disorders other than DM, explain the types of impairments and limitations that result from them, and provide guidance on how we evaluate endocrine disorders in disability claims under titles II and XVI of the Act in SSR 14-3p.

CITATIONS (AUTHORITY): Sections 216(i), 223(d), 223(f), 1614(a)(3), and 1614(a)(4) of the Social Security Act, as amended; Regulations No. 4, subpart P, sections 404.1505, 404.1508, 404.1509, 404.1512-404.1513, 404.1520-404.1520a, 404.1521, 404.1522, 404.1523, 404.1525-404.1530, 404.1545, 404.1546, 404.1560-404.1569a, appendix 1, and appendix 2; and Regulations No. 16, subpart I, sections 416.905, 416.906, 416.908, 416.909, 416.912-416.913, 416.920, 416.920a, 416.921, 416.922, 416.923, 416.924, 416.924a, 416.924b, 416.925, 416.926, 416.926a, 416.927, 416.928, 416.930, 416.945, 416.946, 416.960-416.969a, 416.987, and 416.994-416.994a.

¹ For simplicity, we refer in this SSR only to initial claims for benefits. However, the policy interpretations in this SSR also apply to continuing disability reviews of adults and children under sections 223(f) and 1614(a)(4) of the Act, and to redeterminations of eligibility for benefits we make in accordance with section 1614(a)(3)(H) of the Act when a child who is receiving title XVI payments based on disability attains age 18.

Introduction

On April 8, 2011, we published final rules in the Federal Register in which we removed the listings for evaluating DM in adults and in children from the Listing of Impairments (listings) because they no longer accurately identified people who are disabled.^{2, 3} We added listing 109.08 for children from birth to the attainment of age 6 who have any type of DM and who require daily insulin. We removed the prior listings for DM and stated in the preamble to the final rules that we would continue to recognize DM as a potential cause of disability. We also stated that we would provide more detailed information about the types of impairments and limitations that result from DM, how we evaluate DM in disability claims, and how we would address the seriousness and difficulty of managing DM in children. We are publishing this SSR to provide the policy guidance we said we would provide in the preamble of the final rules.

POLICY INTERPRETATION

I. DM

A. General

DM is a chronic condition characterized by high blood glucose levels that result

² 76 FR 19692 (2011). The final rules were effective on June 7, 2011.

³ The listings are in 20 CFR Part 404, Subpart P, Appendix 1.

from the body's inability to produce or use insulin. Insulin is a hormone that regulates blood glucose. When the body cannot make enough insulin, a person takes it by injection or through the use of an insulin pump. Although DM usually requires lifelong treatment, medical advances in the diagnosis and treatment of DM have resulted in better management of DM in adults and children.

B. Two Major Types of DM and Their Treatments

1. Type 1 DM. In Type 1 DM, previously known as juvenile-onset DM or insulin-dependent DM, the pancreas does not produce insulin due to an autoimmune destruction of the insulin-producing cells. This results in increased blood glucose levels. The onset of Type 1 DM usually has the following symptoms: polydipsia (increased thirst); polyphagia (increased appetite); polyuria (increased urination); unexplained weight loss; fatigue or drowsiness; and blurred vision.

Type 1 DM develops most often in children but can occur at any age. People with Type 1 DM must take daily insulin to live. They generally check their blood glucose levels prior to each meal and at bedtime; however, more frequent checking may be necessary as prescribed by a physician (for example, DM management of young school-aged children may require more frequent blood glucose level checks). Many children with Type 1 DM experience significant day-to-day variability in their DM, usually due to variations in activity. Depending on the child's age, this may necessitate daily, or even hourly, decision-making and intervention either by an adult or under the close

supervision of an adult.

For each insulin dose, the decision regarding the amount and type of insulin the person needs is based on: current blood glucose level (high, normal, or low); knowledge of the timing and type(s) of insulin the person had earlier in the day; the amount of food the person expects to consume; and the nature of activities the person planned for the next several hours. The total insulin administered each day may consist of various combinations of rapid-acting, short-acting, intermediate-acting, and long-acting insulin.

2. Type 2 DM. In Type 2 DM, previously known as adult-onset DM or non-insulin-dependent DM, the pancreas does not produce enough insulin, or there is failure in the transfer of insulin into the body cells (insulin resistance). People with Type 2 DM have symptoms similar to those of Type 1 DM, but the symptoms are usually not as obvious. Other symptoms include cuts or bruises that are slow to heal, numbness in the hands and feet, or recurrent infections of the skin, gums, or bladder.

Type 2 DM is more common in people with obesity and those who have a family history of DM. The first line of treatment is management of DM through diet and exercise. Oral medication or daily insulin is usually required when the weight loss and diet alone fail to manage blood glucose levels.

C. Hyperglycemia

Hyperglycemia (high blood glucose) means a person does not have enough insulin in his or her body. It can occur when a person does not take his or her insulin, eats too much, or does not exercise enough. It can also occur when a person is sick or is under stress. Symptoms of hyperglycemia include frequent urination, increased thirst, blurred vision, headaches, difficulty concentrating, abdominal pain or nausea, and “fruity-smelling” breath.

1. Chronic hyperglycemia leads to DM complications such as diabetic retinopathy, cardiovascular disease, diabetic nephropathy, and diabetic neuropathy. These complications occur more often in adults than in children because body system and organ changes due to DM develop over time.

2. Diabetic ketoacidosis (DKA) is an acute complication of hyperglycemia and is potentially life-threatening. It is not uncommon for people with Type 1 DM to initially present with DKA. DKA occurs when there is a shortage of insulin, resulting in toxicity in the blood. DKA may result in dehydration and an altered metabolic state with potential neurological, renal, respiratory, or cardiac dysfunction(s). When not appropriately treated, DKA may lead to chronic neurocognitive changes, coma, or even death.

D. Chronic DM Complications

1. Diabetic retinopathy, caused by damage to the small blood vessels in the retina, can result in leakage of blood into the eye and growth of abnormal new blood vessels,

leading to vision loss over time. Symptoms may include pain or increased eye pressure. Nonproliferative retinopathy is an early stage of diabetic retinopathy. Although damage to the eyes from diabetic retinopathy may be permanent, some types of treatment, such as laser surgery, may alter the progression of the retinal changes. Diabetic retinopathy is a specific vascular complication of DM that may develop over time. Glaucoma, cataracts, and other disorders of the eye occur earlier and more frequently in people with DM. See 2.00 and 102.00 in the listings for guidance on evaluating vision loss.

2. Cardiovascular disease (CVD) affects the heart and blood vessels and is more common in people with DM than in people without DM. CVD is a major cause of morbidity and mortality for individuals with DM. People with DM, especially Type 2, have abnormal blood cholesterol and fat levels, which accelerates the development of CVD such as coronary artery disease or peripheral arterial disease (PAD). Amputation and foot ulceration are common consequences of PAD. See 4.00 and 104.00 in the listings for guidance on evaluating CVD.

3. Diabetic nephropathy is damage to the kidneys caused by chronic hyperglycemia. When the kidneys are damaged, protein leaks out of the kidneys into the urine. Damaged kidneys can no longer remove waste and extra fluids from the bloodstream. Diabetic nephropathy is a leading cause of end-stage renal disease. Careful management of blood glucose levels, together with the reduction of a co-morbid condition such as high blood pressure, may slow the damage. See 6.00 and 106.00 in the listings for guidance on evaluating genitourinary impairments.

4. Diabetic neuropathy is permanent nerve damage. The most common types of diabetic neuropathy are peripheral and autonomic. It can affect every organ system in the body and produce abnormal function or a loss of sensation in the affected nerve area distribution. See 11.00 and 111.00 in the listings for guidance on evaluating neurological impairments.

a. Peripheral neuropathy (also known as sensorimotor neuropathy), nerve damage that affects the feet, legs, or hands, can cause pain, numbness, and tingling in toes, feet, legs, hands, and arms, which may subsequently cause difficulty walking and holding onto objects. A loss of sensation, combined with poor blood circulation, makes it common for a person with DM and neuropathy to be unaware of an injury to a lower extremity, where cuts or blisters can turn into ulcerations. The ulcerations may become infected and have difficulty healing. Complications of these ulcerations can include cellulitis (a painful inflammation of the skin and tissues, usually from an infection), gangrene (decomposing soft tissue that often results in amputation), and sepsis (an infection that spreads through the blood stream, potentially causing shock, widespread organ failure, or death).

b. Autonomic neuropathy, nerve damage that affects the heart and blood vessels, digestive system, and urinary tract, can cause dizziness, fainting, nausea, vomiting, and infrequent or frequent urination. It can also cause hypoglycemia unawareness due to nerve dysfunction that affects the body's ability to secrete epinephrine (the hormone adrenaline). Autonomic neuropathy is strongly associated with CVD in people with DM.

E. Hypoglycemia

Hypoglycemia (low blood glucose) means that a person has abnormally low levels of blood glucose (also known as “insulin reaction”). It causes acute symptoms and signs, such as weakness, hunger, sweating, trembling, nervousness, palpitations, and difficulty with concentration. In young children, other symptoms may include inattention, fainting, falling asleep at inappropriate times, unexplained behavior, and temper tantrums. Hypoglycemia can occur when a person takes too much insulin (or a drug that increases insulin resistance), misses a meal, or exercises more than usual. It can also occur when a person takes medications for other health conditions. Episodes of hypoglycemia occur commonly in people with Type 1 DM and occur in some people with Type 2 DM. Episodes of hypoglycemia can occur during sleep or while a person is awake. During sleep, a person is unaware of hypoglycemia, but on awaking may be confused, disoriented, or may complain of a headache or extreme fatigue. Family members or observers may note that the person during sleep is restless, sweating, or even having seizure-like movements. The only sure way to assess for hypoglycemia is to check blood glucose levels while the person is sleeping. This checking does not prevent hypoglycemia; rather, it identifies the acute need to increase blood glucose levels by consuming something like orange juice.

If not treated promptly, hypoglycemia can become severe, causing an inadequate supply of glucose to brain cells, which can lead to complications including seizures or

loss of consciousness, altered mental status, cognitive deficits, permanent brain damage, or death. Complications of hypoglycemia occur more frequently in young children because they are not able to recognize and respond to symptoms of hypoglycemia, and they depend on an adult to check their blood glucose levels. Because children's bodies are growing and developing, they are more sensitive to fluctuations in blood glucose levels brought on by eating, physical activity, and illness.

Daily insulin doses are based on a person's anticipated food intake and physical activity. Proper dosing of insulin requires complex decisionmaking 24 hours a day. For children, it may be difficult to predict daily insulin doses. If an adult administers insulin to a child based on the expectation that the child will consume a certain amount of food and engage in certain activities, but the child does not eat or exercise as expected, the amount of administered insulin may exceed the child's needs and lead to hypoglycemia. Additionally, during episodes of illness, a child's need for insulin will most likely change from his or her customary need.

Hypoglycemia unawareness means a person with DM either cannot recognize or does not experience the symptoms of hypoglycemia. It generally occurs in people who have had DM for a long time and experienced many episodes of hypoglycemia. Hypoglycemia unawareness interferes with a person's ability to control blood glucose levels and puts a person at risk for severe hypoglycemia-related complications. It can result in prolonged hypoglycemia if not treated immediately, resulting in seizure, loss of consciousness, or brain damage.

F. DM and Obesity

Obesity is a complex, chronic disease characterized by excessive accumulation of body fat. It may increase the severity of coexisting or related impairments to the extent that the combination of impairments meets or medically equals the criteria of a listing. Therefore, a person with DM and obesity may have more severe complications than the effects of each of the impairments considered separately.⁴ For example, in adults, neurovascular complications of DM may result in an amputation of a lower extremity. The neurovascular impairment, along with obesity, may make successful rehabilitation with prosthesis more difficult. Although neurovascular complications are rare in children, obesity increases the likelihood of developing these complications.

II. The Sequential Evaluation Process for Adults

We follow a five-step sequential evaluation process when we make a determination or decision whether an adult is disabled due to DM.⁵

A. Work Activity

We determine at step 1 whether an adult with DM is working and, if so, whether

⁴ See SSR 02-1p. For the complete titles of all SSRs cited in this footnote and those following, see the CROSS-REFERENCES section at the end of this SSR. SSRs are available at: http://www.ssa.gov/OP_Home/rulings.

⁵ See 20 CFR 404.1520(a) and 416.920(a).

the work activity is substantial gainful activity (SGA).⁶ If an adult is engaging in SGA, we will find that he or she is not disabled. If an adult is not engaging in SGA, we go on to step 2 of the sequential evaluation process.

B. Severe Medically Determinable Impairment(s)

We determine at step 2 whether an adult has a medically determinable impairment (MDI) that is severe. An MDI must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by a statement of symptoms.⁷ When we evaluate the severity of DM, we consider any symptoms, such as fatigue or pain, that could limit functioning.⁸ If the effects of DM, alone or in combination with another impairment(s), significantly limit an adult's physical or mental ability to do basic work activities, we find that the impairment(s) is severe. We find, however, that the impairment(s) is "not severe" if it has no more than a minimal effect on the adult's ability to do basic work activities. If an adult does not have an MDI that is severe, we find that he or she is not disabled. If an adult does have a severe impairment(s), we go on to step 3 of the sequential evaluation process.

C. Evaluating the Effects of DM under Other Body Systems

We next determine at step 3 whether the impairment(s) meets or medically equals

⁶ See 20 CFR 404.1510 and 416.910.

⁷ See 20 CFR 404.1508, 404.1520(c), 404.1521, 416.908, 416.920(c), and 416.921.

⁸ See 20 CFR 404.1529 and 416.929; and SSR 96-3p.

a listing, which also considers the medical severity of your impairment(s). DM is not a listed impairment for adults. However, the effects of DM, either alone or in combination with another impairment(s), may meet or medically equal the criteria of a listing in an affected body system(s).⁹ Below are some examples of the effects of DM and the body systems under which we evaluate them:

- Amputation of an extremity, under the musculoskeletal system listings (1.00).
- Diabetic retinopathy, under the special senses and speech listings (2.00).
- Hypertension, cardiac arrhythmias, and heart failure, under the cardiovascular system listings (4.00).
- Gastroparesis and ischemic bowel disease (intestinal necrosis), under the digestive system listings (5.00).
- Diabetic nephropathy, under the genitourinary impairments listings (6.00).
- Slow-healing bacterial and fungal infections, under the skin disorders listings (8.00).

⁹ See 20 CFR 404.1509, 404.1525, 404.1526, 416.909, 416.925, and 416.926.

- Diabetic neuropathy, under the neurological listings (11.00).
- Cognitive impairments, depression, anxiety, and eating disorders, under the mental disorders listings (12.00).

D. Assessing Residual Functional Capacity

1. When the effects of DM, alone or in combination with another impairment(s), are severe but do not meet or medically equal the criteria of a listing, we assess an adult's residual functional capacity (RFC).¹⁰ RFC is the most an adult can do despite his or her limitation(s).

2. The combined effects of DM and another impairment(s) can be greater than the effects of each of the impairments considered separately. We consider all work-related physical and mental limitations, whether due to an adult's DM, other impairment(s), or combination of impairments. For example, adults with peripheral sensory neuropathy may have difficulty walking, operating foot controls, or manipulating objects because they have lost the ability to sense objects with their hands or feet. Adults with chronic hyperglycemia may experience fatigue or difficulty with concentration that interferes with their ability to perform work activity on a sustained basis.

3. We then proceed to step 4 and, if necessary, step 5 of the sequential evaluation

¹⁰ See 20 CFR 404.1545 and 416.945; and SSR 96-8p and SSR 96-9p.

process. We use the RFC assessment at step 4 to evaluate whether an adult is capable of performing any past relevant work (PRW) as he or she actually performed it or as the job is generally performed in the national economy. If an adult's RFC precludes the performance of PRW (or if there was no PRW), we use the RFC assessment to make a finding at step 5 about his or her ability to perform other work that exists in significant numbers in the national economy. The usual vocational considerations apply.¹¹

III. The Sequential Evaluation Process for Children

We follow a three-step sequential evaluation process when we make a determination or decision whether a child is disabled due to DM.^{12, 13}

A. Work Activity

We determine at step 1 whether a child is working and, if so, whether the work activity is SGA.¹⁴ If a child is engaging in SGA, we find that he or she is not disabled. If a child is not engaging in SGA, we go on to step 2 of the sequential evaluation process.

B. Severe Medically Determinable Impairment(s)

¹¹ See 20 CFR 404.1560-404.1569a and 416.960-416.969a.

¹² The process described in this section applies to determinations and decisions made for children under title XVI. See 20 CFR 416.924.

¹³ Under title II, we use the adult definition of disability to make disability determinations or decisions for people under age 18.

¹⁴ See 20 CFR 416.910.

We determine at step 2 whether a child has an MDI that is severe. An MDI must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by a statement of symptoms.¹⁵ When we evaluate severity, we consider the effects of DM on the child's functioning, including: limitations as a result of treatment (for example, insulin); and the kinds and extent of help, support, and supervision the child needs compared to that of children the same age who do not have impairments.¹⁶ If the child's DM, alone or in combination with another impairment(s), causes more than minimal functional limitations, we find that the impairment(s) is severe.¹⁷ We find that the impairment(s) is "not severe" if it causes no more than minimal functional limitations. If a child does not have an MDI that is severe, we find that he or she is not disabled. If a child does have a severe impairment(s), we go on to step 3 of the sequential evaluation process.

C. Meets or Medically Equals a Listing, or Functionally Equals the Listings

1. Evaluating DM under the endocrine disorders body system. We have one childhood listing for DM, listing 109.08. We find children with any type of DM who require daily insulin and have not attained age 6 disabled under this listing. We presume such children have not developed adequate cognitive capacity for recognizing and

¹⁵ See 20 CFR 416.908 and 416.924(c).

¹⁶ In 20 CFR 416.924a(b), we provide guidance on factors that are relevant whenever we evaluate a child's functioning.

¹⁷ We presume that all children with any type of DM who require daily insulin and have not attained age 6 have more than minimal functional limitations because they are unable to alert adults to their symptoms of hypoglycemia. Some children age 6 and older with DM who require daily insulin, and who have not developed the cognitive ability for recognizing and responding to hypoglycemia symptoms, also have more than minimal functional limitations.

responding to their hypoglycemia symptoms; that is, they have hypoglycemia unawareness. This means they are unable to participate in their own care at the most basic level because they are unable to alert adults to their symptoms of hypoglycemia. Parents and other caregivers must have near-constant visual contact with these young children to watch for fainting or other signs of impending hypoglycemia so that they may intervene to prevent their children from having a hypoglycemic seizure or becoming comatose or dying. This level of help satisfies an example of functional equivalence in our functional equivalence regulation: the requirement for 24-hour-a-day supervision of a child for medical reasons.¹⁸ Listing 109.08 presumes this level of help is satisfied.

2. Evaluating the effects of DM under other body systems. DM is not a listed impairment for children who are age 6 or older and require daily insulin or for children of any age with DM who do not require daily insulin. However, DM may be of listing-level severity in these children. We determine whether the effects of DM, alone or in combination with another impairment(s), meet or medically equal the criteria of a listing in an affected body system(s).¹⁹ Complications of DM that are linked to chronic hyperglycemia (for example, diabetic retinopathy or nephropathy) develop gradually, making them rare in children. However, some adolescents may start to develop or have early-onset eye or kidney complications or have impaired growth. Below are some examples of the effects of DM and the body systems under which we evaluate them:

¹⁸ See 20 CFR 416.926a(m).

¹⁹ See 20 CFR 416.909, 416.924(a), 416.925, and 416.926.

- Growth impairments, under the growth impairment listings (100.00).
- Diabetic retinopathy, under the special senses and speech listings (102.00).
- Cardiac arrhythmias, under the cardiovascular system listings (104.00).
- Gastroparesis and ischemic bowel disease (intestinal necrosis), under the digestive system listings (105.00).
- Cognitive impairments, depression, anxiety, and permanent brain damage, under the mental disorders listings (112.00).

3. Evaluating the effects of DM under functional equivalence. When the effects of a child's DM, alone or in combination with another impairment(s), are severe but do not meet or medically equal the criteria of a listing in any affected body system(s), we determine whether they result in limitations that functionally equal the listings.²⁰ By "functionally equal the listings," we mean that the child's impairment(s) must be of listing-level severity. In evaluating the effects of a child's DM, alone or in combination with another impairment(s), on his or her functioning, we consider what the child cannot do, has difficulty doing, needs help doing, or is restricted from doing because of his or her impairment(s). We must explain any limitation in a child's ability to function age-

²⁰ See 20 CFR 416.926a; SSRs 09-1p and 09-2p.

appropriately on the basis of an MDI(s).²¹

a. Determining the medical need for 24-hour-a-day adult supervision for children age 6 and older. Children of any age need some level of adult supervision or support in managing their DM that requires daily insulin. However, the mere need for adult supervision does not establish disability.

We presume children with DM who require daily insulin and are under age 6 have not developed the cognitive ability for recognizing and responding to hypoglycemia symptoms and, therefore, have impairments that meet listing 109.08. Generally, children develop the cognitive ability for recognizing and responding to their hypoglycemia symptoms by age 6. However, developmental abilities of children vary greatly. Some children age 6 and older may have the same medical need for adult help and continuous supervision as younger children. We evaluate on an individual case basis whether children age 6 and older have developed cognitive awareness of their hypoglycemia symptoms. Without this awareness, children who require daily insulin are unable to alert adults to their symptoms, and require 24-hour-a-day adult supervision for medical reasons.

When we find that a child with DM has hypoglycemia unawareness, we consider how long the child has had or will have the medical need for 24-hour-a-day adult supervision. For example, a child in elementary school who has only recently been

²¹ See 20 CFR 416.924a(b) and 416.926a.

diagnosed with Type 1 DM may require more time to develop awareness of his or her symptoms of hypoglycemia than an adolescent who has been newly diagnosed.

Some children may have a mental impairment(s) or another physical impairment(s) in addition to DM that also may require 24-hour-a-day adult supervision for medical reasons. We find any child who requires 24-hour-a-day adult supervision for medical reasons disabled under our functional equivalence rules.

b. Determining functional equivalence for all other children with any type of DM.

Children with DM that does not meet or medically equal a listing or children who do not have a medical need for 24-hour-a-day adult supervision may nevertheless have impairments that functionally equal the listings under our rules for evaluating disability in children.

To functionally equal the listings, an impairment(s) must be of listing-level severity; that is, it must result in “marked” limitations in two domains of functioning or an “extreme” limitation in one domain of functioning. Domains are broad areas of functioning intended to capture all of what a child can or cannot do.

When we determine whether a child’s impairment(s) functionally equals the listings, we use the following six domains:

- Acquiring and using information;

- Attending and completing tasks;
- Interacting and relating with others;
- Moving about and manipulating objects;
- Caring for yourself; and
- Health and physical well-being.

When we evaluate a child's functioning in these six domains, we consider how the child functions compared to children the same age who do not have impairments. The first five domains describe the abilities a child uses to develop the skills that he or she uses to function in day-to-day activities. In domain six, we consider the cumulative physical effects of physical and mental impairments and their associated treatments on a child's health and functioning. This domain does not address typical development and functioning. Rather, it addresses how such things as recurrent illness, the side effects of medication, and the need for ongoing treatment affect a child's body; that is, the child's health and physical well-being.

DM, alone or in combination with another impairment(s), may affect a child's functioning in any domain. We evaluate each child's limitations by considering all relevant information from acceptable medical sources (for example, a pediatrician or psychologist), other medical sources (for example, a physical or an occupational therapist), and non-medical sources such as parents, teachers, and other people who know

the child.^{22, 23} We also consider factors such as the:

- Kinds and extent of help, support, and supervision a child with DM needs that exceed what a child the same age would typically need; and
- Effects of DM medications and other treatments, including adverse and beneficial effects.

Some children with DM may have limitations in the domain of Acquiring and using information due to fluctuating blood glucose levels. They may find it difficult to concentrate on and participate in classroom work while at school when they experience low or elevated blood glucose levels. They may miss enough classroom time to affect their learning if they frequently seek help outside of the classroom from a school nurse or other adult for treating hypoglycemia or hyperglycemia. Children with DM may also miss school due to frequent doctor visits, emergency room care, or hospitalizations.

Frequent episodes of hypoglycemia or hyperglycemia may also result in a child having limitations in the domain of Attending and completing tasks at school, at home, or in the community. If a child often does not feel well due to low or elevated blood glucose levels, it may be difficult for him or her to stay focused on activities long enough to complete them in an age-appropriate manner. For example, a child with DM who requires

²² See 20 CFR 416.913(a).

²³ See 20 CFR 416.924a(a).

insulin may have difficulty maintaining attention to details and may make mistakes in his or her schoolwork due to an inability to concentrate.

Children with DM may have limitations in the domain of Interacting and relating with others because they are self-conscious about checking their blood glucose levels throughout the day, administering insulin, and following a special diet in the presence of their peers. They may find it difficult to maintain social contacts or participate in sport activities because they believe their peers may not understand their DM care requirements and will bully or tease them because of their requirements.

If DM or its treatment causes fatigue or weakness that limits a child's fine or gross motor functioning, we evaluate those effects in the domain of Moving about and manipulating objects. For example, a young child who experiences weakness and trembling as a consequence of hypoglycemia, or nausea due to hyperglycemia, may have difficulty with coordination, climbing up and down stairs, and running.

Other children who have DM may have difficulty meeting their emotional and physical wants and needs in ways that are age-appropriate and in comparison to other same-age children who do not have impairments. For example, a child who refuses to use insulin as needed because of embarrassment about injecting it in the presence of peers may have limitations in the domain of Caring for yourself because this action would endanger his or her health.

The ongoing effects of DM and its treatment may affect a child's health and physical well-being. For example, we evaluate the effects of hypoglycemia or DKA in the domain of Health and physical well-being. Managing DM in young children, particularly, requires intensive care from an adult to maintain the child's health and physical well-being. We evaluate such medical fragility in this domain. It is important to remember that the cumulative physical effects of DM and its treatment can vary in kind and intensity, affecting each child differently.

The effects of DM may differ from child to child. We evaluate the effects of a child's DM, alone or in combination with another impairment(s), including the effects of medication or other treatment, in all relevant domains. When considering the functioning of a child with DM, we use the "whole child" approach to evaluate the particular effects of DM on a child's activities in any and all of the domains that the child uses to do those activities, based on the evidence in the case record.

We find a child disabled if the effects of his or her DM, alone or in combination with another impairment(s), result in "marked" limitations in two domains of functioning or an "extreme" limitation in one domain of functioning.

EFFECTIVE DATE: This SSR is effective on [INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER].

CROSS-REFERENCES: SSR 96-3p: Titles II and XVI: Considering Allegations of Pain

and Other Symptoms in Determining Whether a Medically Determinable Impairment is Severe; SSR 96-8p: Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims; SSR 96-9p: Titles II and XVI: Determining Capability to do Other Work—Implications of a Residual Functional Capacity for Less Than a Full Range of Sedentary Work; SSR 02-1p: Titles II and XVI: Evaluation of Obesity; SSR 09-1p: Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The “Whole Child” Approach; SSR 09-2p: Title XVI: Determining Childhood Disability—Documenting a Child’s Impairment-Related Limitations; SSR 09-3p: Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Acquiring and Using Information”; SSR 09-4p: Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Attending and Completing Tasks”; SSR 09-5p: Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Interacting and Relating with Others”; SSR 09-6p: Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Moving About and Manipulating Objects”; SSR 09-7p: Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Caring for Yourself”; SSR 09-8p: Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Health and Physical Well-Being”; and Program Operations Manual System (POMS) DI 22001.001-DI 22001.035, DI 22505.001, DI 22505.003, DI 24510.005, DI 24510.006, DI 24515.061-DI 24515.063, DI 24570.001, DI 25005.001, DI 25010.001, DI 25015.001, DI 25025.001, DI 25201.005, DI 25220.010, DI 25225.001-DI 25225.065, DI 25505.025, and DI 25505.030.²⁴

²⁴ SSRs are available at: http://www.ssa.gov/OP_Home/rulings. POMS are available at:

[FR Doc. 2014-12601 Filed 05/30/2014 at 8:45 am; Publication Date: 06/02/2014]